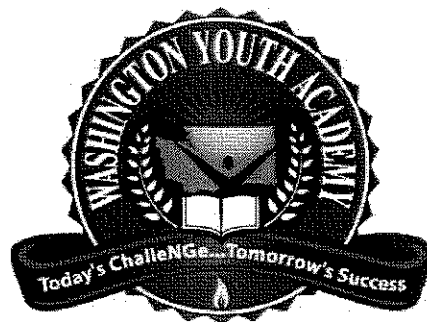


WASHINGTON YOUTH ACADEMY



Today's ChalleNGe...Tomorrow's Success

STUDENT APPLICATION

APPLICATION FOR CLASS:

- ☐ January to June 201__
- ☐ July to December 201__

WA Counties North of I-90
and
Kitsap, Mason Counties

Contact Admission Specialist

Elizabeth "Liz" Bergmann

Phone: (360) 473-2615

elizabeth.bergmann@mil.wa.gov

WA Counties South of I-90
Jefferson, Clallam, Grays Harbor
Thurston and Pierce Counties

Contact Admission Specialist

Kelly Ingalls

Phone: (360) 473-2617

kelly.ingalls@mil.wa.gov

Washington Youth Academy
Admissions Department
1207 Carver Street
Bremerton, WA 98312

Toll Free (877) 228-8947 FAX (360) 473-2623

<http://mil.wa.gov/youth-academy>

Submit application by mail, email or FAX

Application submitted by email contain sensitive personal information, are not received via secure file transfer protocols, and will become part of the Washington Military Department's email vault storage system.



Washington Youth Academy Application



Dear Applicant and Family,

The WYA is part of the National Guard Youth Challenge Program, authorized and funded by the Department of Defense and Office of Superintendent of Public Instruction. The goal of the program is to give youth a second chance to complete their high school education. The program is voluntary and the student must compete for admission. The WYA is a 22-week residential academic intervention using a quasi-military structure to emphasis discipline, personal responsibility, physical fitness, academic excellence, job skills and more.

Eligible students must be:

- 16-18 years old and drug free on the first day of the program.
- Legal resident of United States and Washington state.
- Dropped out or at-risk of dropping out (i.e. behind in credit, behavioral issues, etc.)
- Physically and mentally capable of completing the program.
- Free of pending legal matters. No felony convictions.

Completing and Submitting this Application. The application is in three parts: student information, medical and the mentor application. There are also additional documents that will need to be copied and included in your application. Read the application carefully and provide the information that is asked for. Only completed applications are considered for admission. When your application is complete, you can submit it by:

Mail, Scan/Email or FAX

Washington Youth Academy Admissions Department 1207 Carver Street Bremerton, WA 98312 Toll Free (877) 228-8947 FAX (360) 473-2623

Selecting Students for the Next Class. Student applications that are complete will be reviewed by the WYA. Application Panel. You will be invited to a mandatory onsite orientation if your application is selected. Orientation is an opportunity to get to know you and to see if we think the Academy is a good fit for you. At the same time, you can decide if the Academy is right for you. If during orientation, you prove to us that you are willing to work hard to make changes in your life and complete your education, you will be offered an invitation to the first day of class. If you accept the invitation, your Challenge will begin.

We look forward to receiving your application. Please contact us if you have any questions. We are here to help you achieve your goal of being a successful high school graduate.

Dream Believe Achieve

The Washington Youth Academy Team

Application submitted by email contain sensitive personal information, are not received via secure file transfer protocols, and will become part of the Washington Military Department's email vault storage system.



Washington Youth Academy Application

Application Completion Requirements



- | |
|--|
| <input type="checkbox"/> Student application (Student-1 to Student-6) All boxes are checked and all information is entered. Student and parent/guardian have signed and dated all pages. |
| <input type="checkbox"/> Medical application (Medical-1 to Medical-13) All boxes are checked and all information is entered. Student, parent/guardian and doctor have signed and dated where requested. A behavior health letter must be obtained, if required. |
| <input type="checkbox"/> Mentor application (Mentor-1 to Mentor-6) All boxes are checked and all information is entered. A copy of the mentor's driver's license is included. |

Additional Documents Required for ALL Applicants

- | |
|--|
| <input type="checkbox"/> Social Security Card - card must be signed if the student is 18 or older (copy only) |
| <input type="checkbox"/> Proof of Legal United States (U.S.) Residency - U.S. birth certificate preferred. (copy only)
If NO U.S. birth certificate is available, the ONLY other acceptable forms are:
→ U.S. Passport
→ Federally Recognized Tribal Identification (ID)Card
→ I-551 or I-571 - Green Card or Alien Registration Card
→ N-550 U.S. Certificate of Naturalization
→ N-560 U.S. Certificate of Citizenship |
| <input type="checkbox"/> U.S. Government Issued Photo ID - obtained at the Department of Motor Vehicles (copy) |
| <input type="checkbox"/> Unofficial High School Transcript - obtained from the school |
| <input type="checkbox"/> High School Credit Evaluation - obtained from the school counselor |
| <input type="checkbox"/> Individual Education Plan (IEP) and 3-Year Evaluation or 504 Plan-if applicable (copy from school) |
| <input type="checkbox"/> WATCH Report (Juvenile Criminal History Report) - obtained from the Internet (copy)
→ All applicants must submit this report.
→ Go to https://fortress.wa.gov/wsp/watch/ |
| <input type="checkbox"/> Medical Cards - copy of the front and back |

Documents may be sent separately.

The application is complete when all documents are submitted.

Incomplete applications are not considered for admission.



Washington Youth Academy Application

MANDATORY ELIGIBILITY CRITERIA



PURPOSE: This page lists the eligibility criteria for applicants to attend the Washington Youth Academy (WYA).

STUDENT NAME: AS IT APPEARS ON THE BIRTH CERTIFICATE

Last:	First:	Middle:
-------	--------	---------

	Yes	No
1. Will you be 16-18 years of age on the first day of the program?		
2. Are you a citizen or legal resident of the United States?		
3. Are you a citizen or legal resident of the Washington state?		
4. Have you received a diploma or Graduate Equivalency Degree (GED)?		
5. Are you a high school drop-out?		
6. Are you behind in high school credits?		
7. Have you ever committed a crime?		
8. Are you currently facing criminal charges?		
9. Are you awaiting sentencing for a crime?		
10. Are you currently on parole or probation?		
11. Are you currently employed? Number of hours/week <input type="text"/> Wage \$ <input type="text"/>		
12. Are you free from the use of illegal drugs or substances? Drug testing will take place throughout the program.		
12. Are you physically and mentally capable of participating in the WYA? Reasonable accommodations will be made for identified disabilities. Accommodation will be arranged prior to entry into the program.		
13. Do you currently have an Individualized Education Plan (IEP) or 504 plan? Students with an IEP or 504 Plan are welcome to apply. The IEP/3-year evaluation or 504 Plan must be current and cannot expire during the program session.		

By signing below, you ensure to the best of your knowledge, all information provided is true and accurate.	
Student Signature	Date
Parent/Legal Guardian Signature	Date



Washington Youth Academy Application

STUDENT BACKGROUND INFORMATION

Please print in black ink.



STUDENT NAME: AS IT APPEARS ON THE BIRTH CERTIFICATE

Last:	First:	Middle:
-------	--------	---------

Social Security Number:

Date of Birth:

 / /

Male

☐

Female

☐

Transgender

☐

Student Address:

P.O. Box

Street

City

State

Zip

County

Home

()

Cell

()

Email

Hair Color

Height

Eye Color

Weight

Ethnicity:	Race:	Family Income:	Public Assistance:
Hispanic or Latino <input type="checkbox"/>	American Indian/Alaskan Native <input type="checkbox"/>	<\$15,000 <input type="checkbox"/>	Yes <input type="checkbox"/>
Not Hispanic <input type="checkbox"/>	Asian <input type="checkbox"/>	\$15-25,000 <input type="checkbox"/>	No <input type="checkbox"/>
	Black (Not of Hispanic Origin) <input type="checkbox"/>	\$25-35,000 <input type="checkbox"/>	
	Caucasian or White <input type="checkbox"/>	\$35-45,000 <input type="checkbox"/>	
	Native Hawaiian or Other Pacific Islander <input type="checkbox"/>	>\$45,000 <input type="checkbox"/>	
	Of more than one race or Multiracial <input type="checkbox"/>		
	Other <input type="checkbox"/>		

1. Who do you live with?	
2. How many people live in your household including yourself?	
3. What is the primary language spoken in your home?	
4. Are you married? Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. Do you have children? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" how many?	
6. Is one or both of your parents or legal guardians currently incarcerated? Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. Are you a foster child? Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. Are you adopted? Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. Are you homeless? (Sheltered, unsheltered, sharing housing, motel, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/>	
10. Have you ever been a participant in the WYA or other Challenge Program? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Student's Name (last, first) _____ Date of Birth _____

Student-2



Washington Youth Academy Application

STUDENT BACKGROUND INFORMATION

Please print in black ink.



Education

1. Are you currently enrolled in high school?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "NO" please provide drop-out date.		
2. What is the name of the last high school attended?		
3. What was the last grade completed?	8 <input type="checkbox"/>	9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/>
4. Are you currently home-schooled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Do you have a learning disability?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Have you ever been suspended or expelled from high school?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Date:	Explain:
	Date:	Explain:
7. How did you or your family find out about WYA?		
8. Do you know of anyone else applying for the same class?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If "Yes" who?	

Criminal History

1. Are you currently involved in any legal proceedings?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Are you awaiting trial/sentencing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Are you currently on a diversion?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Are you currently on probation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Have you ever been arrested or convicted of a crime?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Date:	Crime:
	Date:	Crime:

Risk Factors

1. Do you smoke or use tobacco products?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Have you ever abused alcohol or been drunk?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Have you ever used illegal drugs or abused prescription drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If "Yes" what drugs?	
4. Have you ever been treated or hospitalized for drug use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If "Yes" where and when?	
5. Are you a member, affiliated or hang around with a gang?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Are you currently on an At-Risk Youth Petition?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Are you currently on a Truancy/BECCA Petition?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

By signing below, you ensure to the best of your knowledge, all information provided is true and accurate.

Student Signature

Date

Parent/Legal Guardian Signature

Date



Washington Youth Academy Application

CONTACT INFORMATION

Please print in black ink.



Purpose: This form provides routine and emergency contact information about the student's parent or legal guardian. Unless designated otherwise, contact is in the order listed. **Only those listed on this page will be given information and allowed to pick-up for home passes and appointments.**

#1 Primary Parent/Legal Guardian				Male <input type="checkbox"/>		Female <input type="checkbox"/>	
Is this person authorized to pick-up student from the Academy? Yes <input type="checkbox"/> No <input type="checkbox"/>							
Last Name			First				
Address			City				
State		Zip Code		Home Phone		()	
Email				Cell Phone		()	
Primary Language Spoken							
What is your relationship to the student?				Parent <input type="checkbox"/>		Guardian <input type="checkbox"/>	
Other <input type="checkbox"/>		Grandparent <input type="checkbox"/>		Step Parent <input type="checkbox"/>			

#2 Primary Parent/Legal Guardian				Male <input type="checkbox"/>		Female <input type="checkbox"/>	
Is this person authorized to pick-up student from the Academy? Yes <input type="checkbox"/> No <input type="checkbox"/>							
Last Name			First				
Address			City				
State		Zip Code		Home Phone		()	
Email				Cell Phone		()	
Primary Language Spoken							
What is your relationship to the student?				Parent <input type="checkbox"/>		Guardian <input type="checkbox"/>	
Other <input type="checkbox"/>		Grandparent <input type="checkbox"/>		Step Parent <input type="checkbox"/>			

#3 Alternative Emergency Contact				Male <input type="checkbox"/>		Female <input type="checkbox"/>	
Is this person authorized to pick-up student from the Academy? Yes <input type="checkbox"/> No <input type="checkbox"/>							
Last Name			First				
Address			City				
State		Zip Code		Home Phone		()	
Email				Cell Phone		()	
Primary Language Spoken							
What is your relationship to the student?				Parent <input type="checkbox"/>		Guardian <input type="checkbox"/>	
Other <input type="checkbox"/>		Grandparent <input type="checkbox"/>		Step Parent <input type="checkbox"/>			

By signing below, you ensure to the best of your knowledge, all information provided is true and accurate.

Student Signature

Date

Parent/Legal Guardian Signature

Date

Student's Name (last, first) _____ Date of Birth _____

Student-4



Washington Youth Academy Application

STUDENT GOALS

Please print in black ink.



Purpose: By applying to the WYA, you are demonstrating a desire to change your life and create a successful future for yourself. The Student Goals page is your opportunity to tell us why you want to be considered for admissions. **Only the student should complete this page.**

What do you hope to accomplish by attending the WYA?	X
Opportunity to earn up to 8 high school credits.	
Opportunity to return to my home high school and graduate with a diploma.	
Opportunity to enroll in a vocational training program.	
Opportunity to earn a Graduate Equivalency Degree (GED).	
Opportunity to achieve a personal sense of accomplishment, self-esteem and discipline.	
Opportunity to explore careers.	
Opportunity to gain job skills for employment.	
Opportunity to learn and apply to colleges.	
Other: Specify	

*The National Guard Youth Challenge program is a 17 ½ month commitment.
This is your opportunity to convince us that you have thought about the changes you want to make in your life and the commitment you will bring to the Academy.*

Please write a personal statement about why you want to attend this program, what you hope to achieve, and how you believe this experience will help you accomplish your educational and career goals. Statement should be a minimum of 100 words or more. Additional paper may be used.

By signing below, you ensure to the best of your knowledge, all information provided is true and accurate.	
Student Signature	Date
Parent/Legal Guardian Signature	Date



Washington Youth Academy Application

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Please print in black ink.



Purpose: In processing your application, there may be a need to confirm or clarify personal information you've provided with an outside agency. This form authorizes us to contact those agencies and exchange information, if necessary, to properly review and evaluate your application.

Student Name:			
Date of Birth:			
County where student currently lives:			
Other Washington counties where student has lived:			

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the State of Washington, its counties, its cities, and its agencies including school districts and treatment program facilities, to submit and/or exchange all pertinent information with the Washington Youth Academy (WYA) regarding, but not limited to the following: substance abuse history, referral history, court status, family or social services interventions, documented medical conditions, and any other information requested by the WYA relevant to the health, safety, welfare, and quality of life of the student named above.

I understand that these records are protected under the federal or state confidentiality laws or regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. WYA is in compliance with the most prominent of the federal protections for participant privacy including the Family Educational Rights and Privacy Act (FERPA). Also known as the "Buckley Amendment" FERPA protects the confidentiality of student records to some extent, while giving students the right to review their own records.

I also understand that I may revoke this consent at any time except to the extent that action has been taken. This consent automatically expires thirty-six (36) months from the date my application is accepted and I am officially registered as a student in the WYA.

By signing below, you ensure to the best of your knowledge, all information provided is true and accurate.

Student Signature

Date

Parent/Legal Guardian Signature

Date

WASHINGTON YOUTH ACADEMY



Today's Challenge...Tomorrow's Success

MEDICAL APPLICATION INSTRUCTIONS

The medical application is a very important part of the admissions process. It requires the applicant to follow specific directions and to complete all pages with honesty and integrity.

The applicant will take the ENTIRE MEDICAL APPLICATION to the doctor for the physical exam. The doctor will review the answers that the student provides on Medical-1, prior to the exam.

The chart below explains who should be completing and signing each form.

Complete ✓	Pages	Who completes the form.	Who signs the form.
<input type="checkbox"/>	Medical-1	Student	Student, Parent/Guardian and Doctor
<input type="checkbox"/>	Med-2 & 3	Doctor	Doctor
<input type="checkbox"/>	Medical-4	Student or Parent/Guardian	Doctor
<input type="checkbox"/>	Medical-5	Doctor and Student	Doctor, Student, Parent/Guardian
<input type="checkbox"/>	Medical-6	Student	Student and Parent/Guardian
<input type="checkbox"/>	Medical-7	Student or Parent/Guardian	No signature required
<input type="checkbox"/>	Medical-8	Dentist	Dentist
<input type="checkbox"/>	Medical-9	Student or Parent/Guardian	No signature required
<input type="checkbox"/>	Medical-10	Student or Parent/Guardian	Parent/Guardian
<input type="checkbox"/>	Medical-11	Student or Parent/Guardian	Student and Parent/Guardian
<input type="checkbox"/>	Medical-12	Student or Parent/Guardian	Student and Parent/Guardian
<input type="checkbox"/>	Medical-13	Student or Parent/Guardian	Student and Parent/Guardian

The application is complete when all questions are answered and pages are signed.



Washington Youth Academy Application

Applicant's Self-Reporting Medical History



Please use additional pages as needed for explanations.

Student Name:	Date of Birth: / /
---------------	--------------------------

1. Have you been hospitalized overnight in the past 5 years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" explain		
2. Have you had surgery in the past 5 years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" explain		
3. Are you missing any paired organs (kidney, lung, testicle?)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" explain		
4. Have you ever passed out during exercise?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" explain		
5. Have you had a head injury in the past 5 years? (Concussion or unconsciousness)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" how many times?		
When was the last time?		
How severe was each one?		
6. Are you currently using any prescription medications, pills or inhalers?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" explain		
7. Have you ever had heat exhaustion, heat stroke and/or heat cramps?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" explain		
8. Have you ever had numbness, tingling in your arms, hands, legs or feet?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" explain		
9. Have you ever thought about committing suicide?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" explain		
10. Have you ever attempted suicide?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" explain		
11. Have you ever been diagnosed with ADD or ADHD?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" explain		
12. Do you have a history of violent outbursts and/or difficulty managing your anger?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" explain		

By signing below, you ensure to the best of your knowledge, all information provided is true and accurate.	
Student Signature	Date
Parent/Legal Guardian Signature	Date

I have reviewed the answers given by the student.		
Physician's Signature	X	Date
Physician's Printed Name	X	/ /



Washington Youth Academy Application

Sports Physical Form - MUST BE WITHIN 1 YEAR OF ENTRY



Physicians Please Note

The WYA is a 5½ month residential program that conducts rigorous physical training daily.
Our physical training program is taken directly from the US Army Physical Training manual.
Our focus is on 3 stages of exercise: toughening, conditioning and sustainment. Students will run several times a week, and develop muscular strength and endurance through calisthenics and cross-fit exercise.

STUDENT NAME

Last:	First:	Middle:
-------	--------	---------

Student Address (Street, City, State, Zip)

Date of Birth

 / /

Date of Exam	Height	Weight	Present Health
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	Good <input type="checkbox"/> Average <input type="checkbox"/> Poor <input type="checkbox"/>

2. Allergies (include medications, insect bites/stings, common foods, latex, pollen...)
<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>

3. Current Medications	Regular or Intermittent	How Administered
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

4. Physical Exam and Medical History

CHECK EACH ITEM. IF "YES" add the age of occurrence/onset and explain on page Medical-3.

	Yes	No	Age		Yes	No	Age
Adverse reaction to medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Frequent trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Arthritis, rheumatism or bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Frequent/painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Bacterial/viral infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Hay fever or allergic rhinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Bed wetting since age 12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Blood in sputum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Head Lice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Bone, joint or other deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Heart trouble or murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Hemorrhoids/rectal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Chronic coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Chronic or frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Cramps in legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Household contact with TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Depression or excessive worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Illegal substances use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Jaundice or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Easy fatigability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Kidney stone/blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Lack vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Epilepsy or seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Loss of finger or toe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Eye surgery to correct vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Loss of memory or amnesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Frequent indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Nerve injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

4. Physical Exam and Medical History (Continued)

CHECK EACH ITEM. IF "YES" add the age of occurrence/onset and explain below.

	Yes	No	Age
Nervous trouble of any sort			
Pain or pressure in chest			
Painful or trick shoulder or elbow			
Palpitation/ pounding heart			
Paralysis (including infantile)			
Parent/sibling sudden death			
Parent/sibling with cancer			
Parent/sibling with diabetes			
Parent/sibling with heart disease			
Parent/sibling with stroke			
Periods of unconsciousness			
Plate, pin or rod in any bone			
Recent gain/loss of weight			
Recurrent back pain or injury			
Recurrent ear infection			
Rheumatic fever			
Scarlet fever			
Severe tooth or gum trouble			
Sexually transmitted disease			

	Yes	No	Age
Shortness of breath			
Sickle cell disease			
Sinusitis			
Skin disease			
Sleepwalking			
Stomach/intestinal problems			
Stutter or stammer			
Sugar or albumin in urine			
Suicide attempt or plans			
Swollen or painful joints			
Thyroid trouble or goiter			
Tobacco use			
Trick or lock knees			
Tuberculosis or Positive TB test			
Tumor, growth, cyst, cancer			
Wear a brace or back support			
Wear a hearing aid			
Wear corrective lens			
X-ray or other radiation therapy			

5. Vision Exam

Right 20/___	Left 20/___	Pupils - Equal/Unequal
Corrected	Yes <input type="checkbox"/>	No <input type="checkbox"/>

6. Females Only

Treated for a female disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Change in menstrual pattern	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Date of last period		
Date of last pap smear		

Physician Comments on All "Yes" Answered Questions in Physical - attach additional paper if necessary.

Physician's Clearance for Participation in the Washington Youth AcademyStudent is cleared for participation with NO Restrictions Yes ☐ No ☐

If "NO" please explain

Physician's Signature	X	Date
Physician's Printed Name	X	/ /

Examining Facility Stamp

Additional Comments:

Student's Name (last, first) _____ Date of Birth _____



Washington Youth Academy Application

Over-the-Counter (OTC) Medications Authorization



The following list of medications will be used for health complaints while student is attending the WYA

Health Complaint	Examples of Medications Used
Acne	Phisoderm cleanser
Allergies	Claritin, Zyrtec, Allegra
Athlete's Foot	Lotrimin, Tinactin spray
Bee Sting	Benadryl cream/spray, Calamine
Cold/cough/sore throat	Dayquil/Nyquil, Mucinex, Mentholatum, various throat lozenges
Constipation	Benefiber, Miralax
Cramps	Midol (or equivalent)
Cuts/scrapes/lacerations	Betadine, bacitracin, triple antibiotic ointment (TAO)
Diarrhea	Imodium
Ear care	Debrox
Eye irritation	Artificial tears
Ingrown toenail	Epsom salt soak, Dr. Scholl's bandage
Irritated skin/bug bites	Aloe, calamine, Benadryl cream/spray, hydrocortisone cream
Lice treatment	RID lice killing shampoo/spray (or equivalent)
Minor burns/sunburn	Aloe, sunscreen lotion/gel/spray
Nosebleeds	Ocean spray, Afrin
Pain/fever/headache	Tylenol, Ibuprofen, Aleve
Sore muscles	Ben Gay, Epsom salt
Sore rectum	Preparation H
Upset stomach/heartburn	TUMS, Pepcid, Prilosec, Pepto-Bismol (or equivalent), Nexium

This is considered a standing order for individual students only during the 22-week program.

I authorize WYA medical staff to give OTC medications (per label instructions) for the treatment of minor injuries and illnesses as listed above. Before giving any medications, the medical staff will check the medical history, allergies and any other medications that are taken to make sure there is no potential for interaction.

I give the WYA medical staff permission to treat my patient's minor illnesses with the OTC meds listed above.

Physician's Signature	X	Date
Physician's Printed Name	X	

Examining Facility Stamp

Additional Comments:



Washington Youth Academy Application

Medication at WYA Form Physician/Parent/Student Authorization



I give permission to the medical staff to administer the medication(s) listed below and to communicate as warranted with the undersigned physician regarding my child's medication. I hereby agree to indemnify and hold forever harmless the WYA and their respective officials, agents, servants, and employees against loss from any and all claims, demands, or actions in law or in equity that may hereafter at any time be made or by said minor or by anyone on behalf of said minor for the purpose of enforcing a claim for damages on account of any injuries or loss sustained in consequence of the aforesaid assistance, and we do hereby waive any and all rights of exemption, both as to real and personal property, to which we may be entitled under the laws of this or or any other state as against such claim for reimbursement or indemnity.

Parent/Guardian Printed Name		
Parent/Guardian Address		
Work Phone	Cell Phone	Home Phone

Student Signature	Date
Parent/Legal Guardian Signature	Date

Physician's Orders

(To be completed by Licensed Health Professional)

Please list all prescription medication. All medications to be given by Nebulizer must be provided in individual unit doses. Inhalers: The physician must sign consent to carry inhaler on person.

Medical Condition	Medication Name	Strength	Dosage	Route	Physician Signature

Student's Name (last, first) _____ Date of Birth _____

Medical-5



Washington Youth Academy Application

Behavior Health Requirement



If you have ever received mental health services or have been hospitalized for behavioral health reasons, you will need to provide additional information with your application.

Below is a questionnaire to assist you in determining if this is necessary.

1. Have you ever been diagnosed and/or treated by a Therapist/Psychiatrist for:		
	Anger management	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Anxiety	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Bipolar disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Conduct disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dissociative disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Oppositional defiant disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Panic attacks	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Post traumatic stress disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Schizophrenia	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Violent outbursts	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Other: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Have you ever been hospitalized for a suicide attempt?		Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you ever been prescribed medication for mental health reasons, regardless of whether you took it or not?		Yes <input type="checkbox"/> No <input type="checkbox"/>

If you answered "Yes" to any of these questions, you will need to obtain a letter from a Behavior Health Provider. Please refer to page **Medical-7** for instructions.

By signing below, you ensure to the best of your knowledge, all information provided is true and accurate.	
Student Signature	Date
Parent/Legal Guardian Signature	Date



Washington Youth Academy Application

Behavior Health Letter



Applicant - Please present this letter to your Behavior Health Provider for assistance securing the documents needed to be considered for the WYA.

Dear Provider,

The client presenting this letter is applying to the Washington Youth Academy. The WYA is a 5½ month residential program with a quasi-military structure, strict adherence to discipline, rules, order and encompasses a high-stress environment. The students live in an open-bay dorms with 50 others and attend school daily. Students wake at 5 a.m. followed directly by physical training, complete 40 hours of service to community and, if successful, earn 8 high school credits. If you would like more information about the WYA, please visit our website (see below).

Please provide the client with a letter addressing the following:

- Client's current diagnosis and former diagnosis if applicable.
- Treatment plan for client to include: frequency of sessions, goals, client's progress, coping/strategies, stress reduction plan, identified triggers etc.
- Any corresponding psychiatric services to include: current medications and dosage, history of medication management/client's responsiveness to the medication, etc.
- Treating Therapist/Psychiatrist's professional opinion on the mental/emotional stability of the client and his or her ability to complete this program.

***Note:** WYA is not equipped to provide on-going mental health counseling services. However, brief intervention and guidance counseling services are provided.

Please contact us if you have questions.

WA Counties North of I-90 and Kitsap, Mason Counties
Contact Admission Specialist
Elizabeth "Liz" Bergmann
Phone: (360) 473-2615
elizabeth.bergmann@mil.wa.gov

WA Counties South of I-90 Jefferson, Clallam, Grays Harbor Thurston and Pierce Counties
Contact Admission Specialist
Kelly Ingalls
Phone: (360) 473-2617
kelly.ingalls@mil.wa.gov

Washington Youth Academy
Admissions Department
1207 Carver Street
Bremerton, WA 98312
Toll Free (877) 228-8947 FAX (360) 473-2623
<http://mil.wa.gov/youth-academy>



Washington Youth Academy Application

Dental Exam Form - MUST BE WITHIN 6 MONTH OF ENTRY



STUDENT NAME

Last:	First:	Middle:
-------	--------	---------

Student Address (Street, City, State, Zip)

--

Date of Birth

/	/
---	---

Date of Exam

Present Dental Health
Good <input type="checkbox"/> Average <input type="checkbox"/> Poor <input type="checkbox"/>

Dental Appliances N/A <input type="checkbox"/>
Type:

Instructions

Place appropriate symbols as shown in the examples below.

Restorable Teeth	Non - Restorable Teeth	Missing Teeth	Replaced by Dentures	Fixed Partial Dentures
u	/	x	x x x	(x)
1 2 3	1 2 3	1 2 3	1 2 3	1 2 3
32 31 30	32 31 30	32 31 30	32 31 30	32 31 30
0	/	x	x x x	(x)

Dental Evaluation

Right	1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16	Left
	32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17	

Dentist's Summary and Elaboration of Dental Health. (Please list dental work that needs to be completed in the next 6 months, including fillings, extractions, etc.) **Attach treatment plan with scheduled appointments noted.**

Dentist Signature	X	Date
Dentist Printed Name	X	/ /

Examining Facility Stamp

Additional Comments:



Washington Youth Academy Application

Immunization Instructions

Immunizations **MUST BE** reported on the WYA form only.



All applicants are required to report immunization they have received.

This is reported on the **Certificate of Immunization Status Form (CIS)** on the next page.

Please follow the instructions below to ensure this is accepted by the Admission staff.

Checklist

- ☐ Box #1 - Print the student's name, birthdate and gender.
- ☐ Box #2 - Print the student's parent/guardian name.
- ☐ Box #3 - Parent/guardian signs and dates.
- ☐ Box #4 - If the student has had chickenpox, note the disease history.
- ☐ Box #5 Using the student's immunization record, copy each immunization in the appropriate box on the form. Each line should have the vaccine name and the date given. (See example below.)

		Date		
Vaccine	Dose	Month	Day	Year
♦Hepatitis B (Hep B)				
Hep B	1	3	27	1999
Hep B	2	6	4	1999
Hep B	3	9	28	2000

Applicants must meet the Required Vaccinations in order for their application to be considered.

Required Vaccinations

Diphtheria, Tetanus, Pertussis (DTaP)

5 doses with the last dose after 4th birthday.

4 doses are acceptable if the last dose is AFTER the 4th birthday.

Tetanus, Diphtheria, Pertussis (Tdap)

1 dose required for all students.

Hepatitis B (Hep B)

3 doses required for all students.

Polio (IPV, OPV)

4 doses with the last dose before 4th birthday.

Measles, Mumps, & Rubella (MMR)

1st dose after 1st birthday.

2nd dose AFTER 13th month of age.

Varicella (chickenpox)

2 doses required for all students.

Student's Name (last, first) _____ Date of Birth _____

Medical-9



Certificate of Immunization Status (CIS)

DOH 348-013 January 2015

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Information System.

Child's Last Name:

First Name:

Middle Initial:

Birthdate (mm/dd/yyyy):

Sex:

Office Use Only:
Reviewed by: _____ Date: _____
Signed Cert. of Exemption on file? ☐ Yes ☐ No

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

2

I certify that the information provided on this form is correct and verifiable.

- Symbols below:
- ◆ Required for School and Child Care/Preschool
 - Required for Child Care/Preschool Only
 - Recommended, but not required

Vaccine	Dose	Month	Day	Year
◆ Hepatitis B (Hep B)				
1				
2				
3				
or Hep B - 2 dose alternate schedule for teens				
1				
2				
■ Rotavirus (RV1, RV5)				
1				
2				
3				
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
1				
2				
3				
4				
5				
◆ Tetanus, Diphtheria, Pertussis (Tdap)				
1				
■ Tetanus, Diphtheria (Td)				
1				
2				
● Haemophilus influenzae type b (Hib)				
1				
2				
3				
4				
■ Influenza (flu, most recent)				

Vaccine	Dose	Month	Day	Year
◆ Pneumococcal (PCV, PPSV)				
1				
2				
3				
4				
5				
◆ Polio (IPV, OPV)				
1				
2				
3				
4				
◆ Measles, Mumps, Rubella (MMR)				
1				
2				
◆ Varicella (chickenpox)				
1				
2				
■ Hepatitis A (Hep A)				
1				
2				
■ Human Papillomavirus (HPV) - does not print from the IIS; write dates in by hand				
1				
2				
3				
■ Meningococcal (MCV, MPSV)				
1				
2				

Parent/Guardian Signature Required

Date

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified.

Mark option 1, 2, OR 3 below (see # 5 on back)

1) ☐ Chickenpox disease verified by printout from the Immunization Information System (IIS) Must be marked by printout (not by hand) to be valid.

2) ☐ Chickenpox disease verified by healthcare provider (HCP) If you choose this box, mark 2A OR 2B below.
2A) ☐ Signed note from HCP attached OR
2B) ☐ HCP sign here and print name below.

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP)

Date

Printed Name:

3) ☐ Chickenpox disease verified by school staff from the Immunization Information System

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.

Signed lab report(s) MUST also be attached.

☐ Diphtheria ☐ Mumps ☐ Other: _____
☐ Hepatitis A ☐ Polio
☐ Hepatitis B ☐ Rubella
☐ Hib ☐ Tetanus
☐ Measles ☐ Varicella

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP)

Date

Printed Name:

Student's Name (last, first)

Date of Birth

Medical-10



Washington Youth Academy Application

Understanding of Limited Medical Services

Page 1 of 2



STUDENT NAME

DATE OF BIRTH

Last:	First:	/	/
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Overview:

The Washington Youth Academy is NOT a hospital, medical, dental or mental health clinic. We have a licensed nurse on staff. For this reason, we are unable to accept applications from students who require ongoing medical or dental care for conditions that originated prior to arrival at the program or that develop after enrollment that prevents their full participation on a daily basis. Minor illnesses and injuries that arise during the program are handled on a "sick call" basis. Students with more serious illnesses or injuries will be taken to a local clinic or hospital emergency room as appropriate. Please note, if the illness or injury is serious, it could jeopardize the student's continued enrollment. The WYA does not have staff available to transport students to frequent medical, dental or vision appointments or provide ongoing treatment or care. Students with medical issues that will impact their daily participation will be dismissed and sent home. The students can reapply to a future class and compete for admission as long as they are in good standing in all other areas. Any periodic appointments for preventative medical, dental or vision care must be made when the student is at home during a scheduled break or "home pass". Appointments scheduled while on home pass should not overlap with the student's scheduled time for return, as this will put the student at risk of not completing the required training and attendance for successful completion. These policies and procedures are intended and designed to ensure the safety, health and welfare of the students and staff of the WYA.

IT IS IMPERATIVE STUDENTS ARE FORTHCOMING AND HONEST ABOUT ALL MEDICAL AND MENTAL HEALTH QUESTIONS. THE FOLLOWING CONDITIONS, WHETHER DISCLOSED OR NOT MAY PREVENT ENROLLMENT.

- Extensive use of multiple medications necessary to treat multiple conditions on a daily basis.
- Extensive dietary restrictions medically required by a physician.
- Previous or current injuries/surgeries that prevent daily participation in all physical and mental activities.
- Dental conditions or appliances that will require near-term or ongoing treatment or that will impact the student's ability to participate in daily activities.
- Conditions or medications that adversely react to or have side effects impacted by rigorous physical activity or seasonal weather conditions that may compromise the health, safety or welfare of the student or his/her fellow students and staff.
- Historic or current conditions requiring medical, psychological or psychotic intervention for suicide prevention, manic depression, anxiety, etc. The WYA does not provide mental health care services.

IMPORTANT NOTE: Participants must provide full and accurate information concerning any and all medical and psychological conditions—as outlined above—at the time of application and report any and all changes to said conditions prior to the beginning of the program.

A complete physical exam by a licensed medical examiner must be completed no more than 1 year from the start of the program. After the start of the program, if an undisclosed condition is identified, the student will be dismissed from the program and returned home. The WYA cannot and will not assume any financial or personal liability or risk for participants that have previous medical, physical or mental health conditions or disorders that could or would be impacted by the rigorous nature of the program.



Washington Youth Academy Application

Understanding of Limited Medical Service

Page 2 of 2



Policies Governing Medications and Medical Care

- All required prescription and non-prescription medications must be disclosed in advance during the application process.
- All potential side effects and limitations of required medications must be disclosed at time of application.
- A medical release and approval to participate must be signed by a doctor and received by the Admissions Office before final acceptance can be issued.
- Parents/legal guardians are entirely responsible for all medical costs, including prescription medications and refills, that may be incurred by the student while attending the WYA.
- Parents/legal guardians are responsible for all medical, dental, vision and psychological care before, during and after attending the WYA.

Medical Insurance Policy

→ **Initial** _____ I understand that the WYA, Washington Military Department (WMD) and the State of Washington are NOT providing any medical insurance coverage for my child to attend the WYA. Medical services provided by a billing medical or emergency service will not be paid by the WYA, WMD or the State of Washington.

→ **Initial** _____ I understand and agree I am financially responsible for all medical services provided by a billing medical or emergency service provider which may include: medical services, medical testing, treatment/care, prescriptions, surgery, ambulance services or any form of emergency services.

→ **Initial** _____ If insurance coverage is provided, I accept responsibility for billing for deductible amounts, co-insurance, non-covered services or services not paid as determined by the insurance carrier. I understand if there is no insurance or the insurance terminates (coverage no longer exists), I agree to pay for all bills associated to medical or emergency services. The provider's billing for uninsured services I would be responsible to pay may include additional fees such as finance charges or other service-related charges.

Primary Parent/Guardian Date of Birth		
Primary Parent/Guardian's Employer		Unemployed/Retired <input type="checkbox"/>

Acknowledgement of Understanding

I understand and agree to be responsible for all medical, dental and mental health care of my youth during, before and after participation in the WYA. In the event that I cannot be contacted through reasonable efforts, I hereby empower and grant WYA staff permission to provide medical care and/or transport my child to a local medical clinic, urgent care center and/or medical institution for further medical evaluation. I understand, should my child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such are initiated. I further understand, once my child reaches the age of majority, my consent for treatment is no longer required. I understand that I am entirely responsible for all medical costs including prescription medication. By signing this, I acknowledge that I have read and understand this consent.

By signing below, you ensure to the best of your knowledge, all information provided is true and accurate.	
Student Signature	Date
Parent/Legal Guardian Signature	Date



Washington Youth Academy Application

Authorization to Release Medical Information



STUDENT NAME

DATE OF BIRTH

Last:	First:	/	/
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I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the released information may be subject to re-disclosure by the recipients only as required to process a claim for benefits and no longer be protected by federal privacy regulations.

Medical Provider

The Washington Youth Academy, located at 1207 Carver St., Bremerton is a division of the Washington Military Department (WMD) and is authorized to receive and use the information in connection with my medical history, treatment and physical or mental health examination. I further authorize that a photocopy of this medical release may be used by the Washington Youth Academy to request and obtain medical information.

Specific description of information: complete medical record for all dates of service and all admissions including, but not limited to history and physical exam; progress notes; office notes and letters; office chart; laboratory reports; diagnostic test reports including, but not limited to MRI, CT scan, bone scan, x-ray reports or films, inpatient admissions and discharge reports; and physical therapy. This information may include medical services including: **psychiatric care, alcohol and drug rehabilitation** and communicable diseases that may also affect my attendance in an intense residential program.

The purpose of use or disclosure of patient information is for my application and attendance in a residential education program. Patient information may be used or disclosed to determine, administer and/or coordinate a treatment plan and/or litigate a claim. Patient information may be re-disclosed to the parties, their agents and representatives; to the WYA and the WMD independent medical examiners and/or care providers contracted by the WYA patient's private insurance or health program coverage provided by the State of WA Washington entities involved in any third party action arising out of providing medical care, the Attorney General's Office, county and/or district courts, and any of my past or present health care providers.

- **I understand** that I am entitled to receive a copy of this authorization.
- **I understand** that I may revoke this authorization at anytime by notifying the providing organization in writing; however, such revocation will not affect any actions the provider took before it received the revocation. Any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.
- **I understand** that I may refuse to sign this form; however, the lack of appropriate medical information may affect the processing of my application or attendance in the program.

By signing below, you ensure to the best of your knowledge, all information provided is true and accurate.	
Student Signature	Date
Parent/Legal Guardian Signature	Date

WASHINGTON YOUTH ACADEMY



Today's ChalleNGe...Tomorrow's Success

MENTOR SELECTION INSTRUCTIONS

As an applicant for the Washington Youth Academy, you will need to select an adult mentor who will help you be successful during the 5½ month Residential phase and the Post-Residential phase (1 year) after you return home. The mentor you select will play a very important role in your life for 17½ months. Select your mentor carefully.

A mentor should be selected using the following criteria:

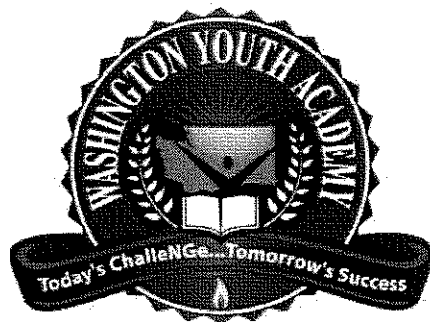
• Be 25 years old or older.
• Be the same gender/sex as you.
• Not an immediate family member or live in your household.
• Live within a reasonable distance of you.
• Not a family member of a current student at the Academy.
• No criminal history involving sex crimes.
• No felonies and crimes involving alcohol or substance abuse within the last 5 years.
• Be able to provide a government issued Social Security number.
• Not be your military recruiter.
• Willing to mentor for 17½ months.

Finding a mentor can sometimes be a difficult process. Here are good places to look:

• School teachers, counselors, coaches, JROTC leaders.
• Parents' work associates, friends, neighbors.
• Extended family members - aunts, uncles, cousins.
• Community organizations (Lion's Club, Kiwanis, Rotary, Elk's, VFW, Soroptimist.)
• Religious organizations (Pastor, Imam, Rabbi.)

When you have made your selection, give your Mentor Nominee the WYA Mentor Application to complete. He or she can complete the application and return it to you to include in your application or mail it separately to the Academy.

WASHINGTON YOUTH ACADEMY



Today's Challenge...Tomorrow's Success

MENTOR APPLICATION

APPLICATION FOR CLASS:

- ☐ January to June 201__
- ☐ July to December 201__

WA Counties North of I-90 and Kitsap, Mason Counties
Contact Admission Specialist
Elizabeth "Liz" Bergmann
Phone: (360) 473-2615
elizabeth.bergmann@mil.wa.gov

WA Counties South of I-90 Jefferson, Clallam, Grays Harbor Thurston and Pierce Counties
Contact Admission Specialist
Kelly Ingalls
Phone: (360) 473-2617
kelly.ingalls@mil.wa.gov

Washington Youth Academy
Admissions Department
1207 Carver Street
Bremerton, WA 98312
Toll Free (877) 228-8947 FAX (360) 473-2623
<http://mil.wa.gov/youth-academy>

Submit application by mail, email or FAX

Application submitted by email contain sensitive personal information, are not received via secure file transfer protocols, and will become part of the Washington Military Department's email vault storage system.



Washington Youth Academy Application



MISSION STATEMENT

The Mission of the Washington Youth Academy (WYA) is to provide a highly disciplined, safe, and professional learning environment that empowers at-risk youth to improve their educational level and employment potential and become responsible and productive citizens of the State of Washington.

ABOUT US:

The WYA is part of the National Guard Youth Challenge Program, authorized and funded by the Department of Defense and Office of Superintendent of Public Instruction. The goal of the program is to give youth a second chance to complete their high school education. The program is voluntary and the student must compete for admission. The WYA is a 22-week Residential Academic Intervention using a quasi-military structure to emphasize discipline, personal responsibility, physical fitness, academic excellence, job skills and more. After graduating from the WYA, the student continues to work with an adult mentor. This positive relationship supports the student during the Post-Residential phase. Each student is required to have a mentor in order to attend.

MANDATORY ELIGIBILITY REQUIREMENTS TO BE A MENTOR:

1. Should be at least 25 years old (some exceptions apply; former graduates must be at least 21 years old).
2. Must be of the same gender/sex as the student.
3. Should NOT be a member of the family (including parents, in-laws, significant others of parents, siblings, grandparents), nor a current resident of the same address.
4. Mentor must live within a reasonable distance to the student during the post-residential phase.
5. Mentor may not be an immediate family member of a current student in the residential phase.
6. Must not have a criminal history involving sex crimes. Must also be free of felonies and crimes involving alcohol or substance abuse within the last seven years.
7. Must be able to provide a government issued Social Security Number. (If unable to provide a government issued SSN, you may provide at your own cost, fingerprinting through the Washington State Patrol.)
8. Should NOT be serving in an official capacity as the student's military recruiter.
9. Willing to MEET EXPECTATIONS OUTLINED ABOVE for up to 17½ months with four contacts per month, 4-hours personal contact each month during post-residential phase.

DISQUALIFYING FACTORS:

1. Conviction for a sex offense.
2. Felony conviction within the last five years.
3. Convictions for alcohol, drug, or substance abuse within the last five years.
4. Failure to follow through on commitment on previous WYA or Challenge mentorships.
5. Inability to provide a government issued SSN and/or fingerprint screening.

DOCUMENTATION OF CONFIDENTIALITY:

Please note and understand that we must ask for personal and sensitive information in the application process. This information will be used to conduct a criminal background check and a sexual offender registry check by law enforcement agencies. The application forms and the information therein, will be kept confidential and will be disclosed to law enforcement agency if required.



Washington Youth Academy Application

PROSPECTIVE MENTOR INFORMATION

Please print in black ink.



STUDENT YOU WOULD LIKE TO MENTOR	Last:	First:
---	--------------	---------------

MENTOR NAME

Last:	First:	Middle:
--------------	---------------	----------------

Date of Birth:

/	/	/
---	---	---

Male

Female

☐☐

Marital

Status

Married ☐

Divorced ☐

Single ☐

Widowed ☐

Mentor Address:

Mailing		Home ()
Physical		Cell ()
City		Work ()
State	Home email	
Zip	Work email	

Race:

American Indian/Alaskan Native <input type="checkbox"/>	Caucasian or White <input type="checkbox"/>
Asian <input type="checkbox"/>	Native Hawaiian or Other Pacific Islander <input type="checkbox"/>
Black (Not of Hispanic Origin) <input type="checkbox"/>	Of more than one race or Multiracial <input type="checkbox"/>

General Information:

How long have you been a resident of Washington state?	Years	Months
What other states have you lived in during the last 10 years?		
How do you know this student?		
Are you a family member of an applicant for the incoming class?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you a family member of a Washington Youth Academy employee?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
What is your primary spoken language?		
If this match is not successful, would you mentor another student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Employment Information:

Employer Name			Employer Phone Number	
Employer Address			()	Ext:
City		State		Zip Code
Job Title				
Dates of Employment	/ /	to	/ /	
Employment Status	Full-Time <input type="checkbox"/>	Part-Time <input type="checkbox"/>	Temp <input type="checkbox"/>	Volunteer <input type="checkbox"/>
	Retired <input type="checkbox"/>	Unemployed <input type="checkbox"/>		

Education:

High School Diploma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Year	GED	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Year
Tech/College Study	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Years Attended				
Certificate/Degree	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Type of Degree				
Military Service	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Branch/Years Served				



Washington Youth Academy Application

Mentor Commitment



STUDENT YOU WOULD LIKE TO MENTOR	Last:	First:
---	--------------	---------------

WHAT'S EXPECTED OF ME AS A MENTOR FOR A WYA STUDENT?

1. Attend one mandatory half-day training session (four hours) at the WYA in Bremerton. This training will be offered on scheduled dates posted on our website. There will also be mentor training offered in Eastern Washington.
2. Maintain weekly contact with the student during the residential phase through letter writing.
3. Maintain personal contact with your student during scheduled home passes, mentor-specific visitations, and/or through attendance at graduation. (Certain exceptions may apply.)
4. Maintain weekly contact and four hours of face to face time with the student during the Post-Residential phase (next 12 months.) On the 15th of every month, you'll submit a brief report on the student's progress.
5. Work together on any revision of the Cadet's Action Plan and actively assist with Post-Residential placement search.

BY MY INITIALS, AS A WYA MENTOR NOMINEE, I UNDERSTAND:

	I must reserve a training date and location with the WYA Mentoring office by phone or email. I understand this is a mandatory training that must be completed.
	I will review the E-learning training on the WYA website at (http://mil.wa.gov/youth-academy/mentor-training) prior to attending the onsite training. This is supplemental training material and is not required.
	My mailing address and phone number will be shared by the program staff with the student and the student's family in order to meet contact requirements.
	I will be required to submit a report on the 15th of every month regarding my contacts and attempted contacts with the student and to update my student's progress.
	I am committing to write my student weekly while in residence (first 5½ months). During the 12 month Post-Residential Phase, I will make a minimum of four contacts, four hours of face to face contact or the combination of both, with my student.

By signing below, I understand the program standards and the commitment I'm making.	
Mentor Signature	Date

Washington Youth Academy
Mentoring Coordinator
1207 Carver Street
Bremerton, WA 98312

Desk (360) 473-2614 FAX (360) 473-2623
<http://mil.wa.gov/youth-academy/mentor-resources>



Washington Youth Academy Application

Mentor Eligibility Pre-Screening



Please use additional pages as needed for explanations.

Purpose: This form requires information about your background that must be answered in order to determine eligibility. The questions are personal and sensitive, as would be expected when the safety and security of a student is involved. A background check authorization form will be sent after your application is processed.

General Information: In order to process your application to be a mentor for a student attending the WYA, we must conduct a reference check, a criminal background check and sexual offender registry check. The WYA staff will not share the information disclosed or the results of the background check to any third party. The WYA does not discriminate on the basis of ethnicity, color, creed, sex, age, religion or sexual orientation.

STUDENT YOU WOULD LIKE TO MENTOR	Last:	First:
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MENTOR NAME

Last:	First:	Middle:
1. Have you ever been arrested for a sex-related crime? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "YES" explain the incident, specify the state and date in which it occurred.		
2. Have you ever been convicted of a sex-related crime? Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. Have you ever been arrested for a crime involving force and/or minors? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "YES" explain the incident, specify the state and date in which it occurred.		
4. Have you ever been convicted of a crime involving violence or threat of violence? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "YES" explain the incident, specify the state and date in which it occurred.		
5. Do you have a history of physical abuse and/or domestic violence? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "YES" was a police report filed? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
If "YES" were charges filed? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
If "YES" were you convicted? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
6. As an adult, have you ever been convicted of a crime involving drug activity or alcohol related offenses?		
Yes <input type="checkbox"/> No <input type="checkbox"/> If "YES" explain the incident, specify the state and date occurred.		
7. Do you have history of alcohol, drug, or substance abuse? Yes <input type="checkbox"/> No <input type="checkbox"/>		
8. Have you ever been convicted of a crime, other than a minor traffic violation? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "YES" what was the crime?		Date
9. Have you been arrested for a crime and are awaiting formal filing of charges or trial? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "YES" what was the arrest for?		Current Status?

Please attach a photocopy of driver's license. Proof of auto insurance will be requested at a later time.

By signing below, you ensure to the best of your knowledge, all information provided is true and accurate.	
Mentor Signature	Date



Washington Youth Academy Application

Mentor Liability Release



Volunteer Mentor Activities: I understand and agree that while volunteering as a mentor I will be engaging in school-based and community-based mentoring activities with my matched Youth Academy Cadet Mentee. I understand that these activities may include a variety of interactions between my mentee and myself to include letter writing/email correspondence, telephone calls, and day visits on and off WYA campus during the residential phase. These activities may have inherent risks such as physical activities, community service or recreational activities. I recognize that I must exercise care in supervising my mentee during the residential and post-residential phase of the mentoring relationship, including planning and selecting the type of activity we participate in during our visits together. Further, I understand that the goal of mentoring is to develop a positive adult/youth relationship. I agree that I am responsible for choosing and conducting all activities with my mentee, and I agree that such activities will be legal and focus on trust and relationship building, open communication and mentee social skill building. These and other related activities will be conducted in the State of Washington during both the Residential and Post Residential Phase.

Volunteer Mentor Status: I also understand and agree I am not an agent, employee or representative of the State of Washington or the WYA in my capacity as a mentor, nor will I claim to be such a representative, officer or employee of the WYA. I will not make any claim of right, privilege or benefit that would accrue to such an employee I do not expect to receive any monetary wages for services rendered during the mentoring period and understand as a volunteer I am not covered for any injury, damage or loss suffered while acting in the capacity as a mentor. I understand that if I use my private motor vehicle in the course of my volunteer mentor duties, it is my obligation to obtain and maintain state required liability insurance to cover any accidents involving my vehicle and to maintain the appropriate legally required vehicle operator's license. I further understand that it is my responsibility to obtain and maintain insurance policies for damage, loss or liability on all personally owned leased or rented equipment I use while performing as a volunteer mentor. The WYA, Washington Military Department and the State of Washington will not provide any liability or other insurance coverage.

Hold Harmless: The Mentor will hold harmless the Washington Youth Academy, Washington Military Department, State of Washington, and its employees while performing his/her mentoring activity, from any and all costs, claims, judgments, and/or awards of damages (both to persons and/or property), which may accrue to or be suffered by any person(s), or property, arising out of mentoring activities.

The Mentor agrees to and hereby does waive any and all claims for personal injury and damages or losses to property, including expenses or lost revenues, in connection with mentoring activities.

In case any claim, suit or action is brought against the Washington Youth Academy, Washington Military Department, State of Washington, and/or its employees, arising out of the mentoring activity, the mentor shall, upon notice of such claim, suit or action, defend the same at his/her sole expense and satisfy any judgment and/or award of damages. This indemnification and waiver shall survive the termination of this release.

Mentor's Signature		Date
Mentor's Printed Name		/ /

If not signed, this application will not be accepted.



Washington Youth Academy Application



Professional Reference - 1 Required

Purpose: As part of the application process, prospective mentors need to submit two references.

A professional reference would be someone in the employment life of the mentor applicant, preferably a person in a supervisory position. In processing this application, it's important we have additional insight into the mentor applicant's character, emotional stability, etc. Please answer these questions with careful consideration. If you wish to have your responses kept confidential, mail this reference to the Academy.

Questions can be directed to Kendra Galloway 360-473-2614.

STUDENT NAME			
MENTOR APPLICANT NAME			
REFERENCE NAME			
REFERENCE ORGANIZATION		TITLE	

1. How long have you known this mentor applicant?	Years		Months	
2. Describe your professional relationship to this applicant.				
3. As far as you are aware, does this applicant have a stable personal life?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
4. Does this mentor applicant work well with others?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
5. Becoming a mentor for the WYA requires 4 hours a month for 17½ months. Do you feel this applicant has the time to make this type of commitment?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
6. Does this applicant over-commit or become involved in too many projects?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
7. Would you see this applicant as a good choice to work with a teenager?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
8. Would you want this applicant to mentor a child in your life?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	

Please rate this applicant in the following areas:	Excellent	Good	Average	Poor	Unknown
Character	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compassion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completes commitments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reachable (returns calls, emails, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:	

Reference's Signature		Date
Reference's Printed Name		/ /

Return this form to the mentor applicant or mail it directly to the WYA Mentoring Coordinator.

Washington Youth Academy Mentoring Office, 1207 Carver St., Bremerton, WA 98312



Washington Youth Academy Application



Personal Reference - 1 Required

Purpose: As part of the application process, prospective mentors need to submit two references.

A personal reference is someone that is a significant person in the life of the mentor applicant. In processing this application, it's important that we have additional insight into the mentor applicant's character, emotional stability, etc. Please answer these questions with careful consideration. If you wish to have your responses kept confidential, mail the reference to the Academy. Questions to Kendra Galloway 360-473-2614.

STUDENT NAME						
MENTOR APPLICANT NAME						
REFERENCE NAME						
REFERENCE ORGANIZATION		TITLE				
1. How long have you known this mentor applicant?		Years		Months		
2. Describe your professional relationship to this applicant.						
3. As far as you are aware, does this applicant have a stable personal life?		Yes <input type="checkbox"/>		No <input type="checkbox"/>		
4. Does this mentor applicant work well with others?		Yes <input type="checkbox"/>		No <input type="checkbox"/>		
5. Becoming a mentor for the WYA requires 4 hours a month for 17½ months. Do you feel this applicant has the time to make this type of commitment?		Yes <input type="checkbox"/>		No <input type="checkbox"/>		
6. Does this applicant over-commit or become involved in too many projects?		Yes <input type="checkbox"/>		No <input type="checkbox"/>		
7. Would you see this applicant as a good choice to work with a teenager?		Yes <input type="checkbox"/>		No <input type="checkbox"/>		
8. Would you want this applicant to mentor a child in your life?		Yes <input type="checkbox"/>		No <input type="checkbox"/>		
Please rate this applicant in the following areas:		Excellent	Good	Average	Poor	Unknown
Character		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morals		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compassion		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completes commitments		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional stability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reachable (returns calls, emails, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:						
Reference's Signature					Date	
Reference's Printed Name					/ /	

Return this form to the mentor applicant or mail it directly to the WYA Mentoring Coordinator.
Washington Youth Academy Mentoring Office, 1207 Carver St., Bremerton, WA 98312